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BY THE COMPTROLLER GENERAL

Report To The Chairman
Committee On Appropriations
United States Senate

OF THE UNITED STATES

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Indian Health Service Not Yet Distributing Funds Equitably Among Tribes

The Indian Health Service's (IHS') equity health care fund was established to correct funding disparities by raising the level of services provided to the neediest tribes by the end of fiscal year 1984. However, the system used to measure and rank tribal needs has weaknesses, making it difficult for IHS to know whether the fund is being distributed according to the tribes' relative needs.

IHS plans to discontinue the equity fund by the end of fiscal year 1984. GAO believes that IHS needs to revise its policy of funding tribes and programs based on the previous year's funding level if it is to eliminate the disparities that will remain. GAO presents two alternative ways IHS could reduce its reliance on the program continuity funding policy.

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COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON D.C. 20548

B-205677

The Honorable Mark O. Hatfield
Chairman, Committee on Appropriations
United States Senate

Dear Mr. Chairman:

Pursuant to Senate Report No. 96-985, dated September 23, 1980, we have reviewed the Indian Health Service's distribution of its fiscal year 1981 equity health care fund. This report points out that fiscal year 1981 equity fund moneys may not have been distributed to the neediest tribes because of weaknesses in the system used to measure and rank tribal health care needs. The report also discusses why the Indian Health Service's policy for distributing the funds available for health services should be revised.

As arranged with your office, we are sending copies of this report to the Secretary of Health and Human Services; the Director, Office of Management and Budget; and other interested parties. Copies will be made available to others upon request.

Sincerely yours,

Charles A. Bowsher

Comptroller General
of the United States

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COMPTROLLER GENERAL'S
REPORT TO THE CHAIRMAN,
COMMITTEE ON APPROPRIATIONS,
UNITED STATES SENATE

INDIAN HEALTH SERVICE NOT YET DISTRIBUTING FUNDS EQUITABLY AMONG TRIBES

D I G E S T

Not all eligible Indians have received an equitable share of Indian Health Service (IHS) funds or services. In May 1980, the Court of Appeals for the Ninth Circuit upheld a lower court opinion that IHS was not meeting its responsibility to certain California Indians who had been receiving relatively less funding than other IHS beneficiaries. The court also criticized IHS for failing to establish a rational basis for distributing its moneys. IHS was ordered to establish a program to provide services to the California Indians comparable to those offered Indians elsewhere in the United States.

To help IHS comply with the court decision, the House and Senate Appropriations Committees earmarked, for fiscal year 1981, about $7.9 million of IHS' $594 million health services appropriation for an equity health care fund. IHS was to use this fund to help it achieve health services funding comparability among tribes.

IHS distributed this fund to tribes using a needs-based ranking system that incorporated standards and criteria to estimate staffing and/or contract care dollars required to provide a range of health services. California Indians received about $5.8 million (74 percent of the fiscal year 1981 equity fund). IHS plans to continue the equity fund in fiscal years 1982-84 to raise the level of services provided to those tribes with the greatest unmet need.

The Senate Committee on Appropriations directed GAO to review IHS' plans for distributing the fiscal year 1981 equity fund and to monitor IHS' reallocation of resources among tribes. (See p. 1.)

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GAO attempted to answer two basic questions:

--Did the equity fund go to the neediest tribes?

--Did IHS develop a system to allocate its appropriations equitably?

IHS MAY NOT HAVE DISTRIBUTED EQUITY FUNDS TO THE NEEDIEST TRIBES

Because of weaknesses in IHS' needs-based ranking system, IHS cannot be sure that it distributed its equity fund moneys to the neediest tribes in fiscal year 1981. GAO noted that IHS

--used inconsistent and unreliable data in developing tribal health care requirements (see pp. 7 to 9);

--understated alternative resources available to tribes to supplement IHS-funded health services (see pp. 9 to 11); and

--excluded from its ranking system two multi-million-dollar programs, distorting the tribal rankings (see pp. 11 and 12.)

IHS has taken some actions to correct these weaknesses. It needs to expand those efforts to ensure that its tribal rankings are correct, the fund is distributed appropriately, and its 4-year objective of funding comparability among tribes is achieved.

IHS NEEDS A MORE EQUITABLE APPROACH TO DISTRIBUTE ITS TOTAL APPROPRIATIONS

The equity fund, by itself, will not correct the major problems associated with the way IHS distributes its health services appropriations. For the bulk of its appropriations, IHS continues to rely on its longstanding policy of "program continuity" funding; i.e., funding programs and tribes based on the previous year's funding level. This policy caused many of the funding inequities that IHS is now attempting to correct through its equity fund. (See pp. 15 to 17.)

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To distribute funds equitably among tribes, IHS needs to use a more rational system for allocating all of its health services appropriations. The equity fund's needs-based ranking system could be used in funding the direct staffing and contract health services portions of tribal health care needs. These services consumed about 60 percent of IHS' fiscal year 1981 health services appropriations. IHS has used this system thus far to distribute only the equity fund, which amounts to less than 2 percent of these appropriated funds. (See p. 16.)

IHS intends to discontinue the equity fund by the end of fiscal year 1984. GAO believes that IHS should not rely on program continuity as the fundamental element in its funding policy if the disparities that will remain are to be eliminated. Also, IHS will need to have in place a system which uses appropriate standards and criteria to assure an equitable distribution of appropriated funds for health services. GAO believes that the equity fund's needs-based ranking system could provide the basis for distributing IHS' health services appropriations. (See pp. 15 to 18.)

RECOMMENDATIONS TO THE SECRETARY OF HEALTH AND HUMAN SERVICES

GAO makes recommendations to the Secretary of Health and Human Services to overcome the weaknesses identified in the equity fund's needs-based ranking system. (See pp. 12 and 13.)

GAO also recommends that the Secretary require the Director of IHS to reduce and eventually abandon IHS reliance on program continuity as a basic element in its funding policy and, in its place, use appropriate standards and criteria to distribute IHS health service funds equitably. (See p. 19.)

AGENCY COMMENTS

The Department of Health and Human Services (HHS) agreed with GAO's recommendation to improve the development of reliable data for estimating tribal health care needs and available resources and has taken or plans to take corrective action. (See p. 13.)

Tear Sheet

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HHS disagreed with GAO's recommendation to include two additional Indian health care programs in the annual comparison of tribal health care services. HHS also disagreed with GAO's recommendation that IHS eventually abandon the funding allocation system--program continuity--now used for distributing the bulk of Indian health services moneys and establish a more equitable funding system for use when the equity fund is discontinued.

GAO does not believe IHS' arguments are persuasive and continues to believe that its recommendations are valid and that HHS should direct IHS to implement them. If such action is not taken, the equity fund mechanism may be needed indefinitely and existing funding inequities may continue. (See pp. 14, 19, and 20.)

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ABBREVIATIONS

GAO	General Accounting Office
HHS	Department of Health and Human Services
IHS	Indian Health Service

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CHAPTER 1

INTRODUCTION

The Indian Health Service (IHS), a component of the Department of Health and Human Services' (HHS') Public Health Service, is responsible for providing comprehensive health care to Indians and Alaska Natives through its system of 48 hospitals, 98 health centers, and several hundred health stations. IHS also contracts with private and public facilities to supplement its direct health care delivery system. In the field, the programs are administered through four program offices and eight area offices.

In fiscal year 1981, IHS received about $594 million to operate its health care system. The House and Senate Appropriations Committees earmarked $7,856,000 of these moneys for an equity health care fund to help IHS comply with a Federal court decision which invalidated the agency's method of distributing appropriated funds to meet Indians' health care needs. In fiscal year 1982, IHS received about $600 million for health services, including an additional $7,636,000 earmarked for the equity health care fund.

In Senate Report No. 96-985, dated September 23, 1980, the Committee on Appropriations directed us to review IHS' plan for distributing the fiscal year 1981 equity fund and to monitor its reallocation of resources.

THE RINCON DECISION

In May 1974, certain California Indians filed a class action suit against IHS and HHS, claiming they had been illegally denied health care services comparable to those offered Indians elsewhere in the United States. The plaintiffs showed that IHS allocated no more than 2 percent of its annual appropriations to California between 1968 and 1978 although, in 1970, California Indians represented over 10 percent of IHS' service population.

In February 1979, the U.S. District Court for the Northern District of California ruled in favor of the plaintiffs (Rincon Band of Mission Indians, et al., v. Joseph A. Califano, Jr., et al.), 1/ concluding that IHS had not established a rational basis for its disproportionate funding, thereby violating the California Indians' constitutional right to equal protection. In the court's judgment, IHS was "obligated to adopt a program for providing health services to Indians in California which is comparable to those offered Indians elsewhere in the United States."

1/464 F. Supp. 934 (N.D. Cal. 1979).

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The U.S. Court of Appeals for the Ninth Circuit affirmed the decision 1/ in May 1980, ruling that IHS had breached its statutory responsibilities to the California Indians. Although it did not specify how or when comparability among tribes was to be achieved, the district court in October 1980 ordered IHS to report on the corrective actions planned to rectify these illegal practices.

IHS PLANS TO DISTRIBUTE THE EQUITY FUND

In its report to the court, IHS identified the equity fund as its planned mechanism for achieving health care funding comparability among tribes. IHS also set forth a plan for distributing--between fiscal years 1981 and 1984--the moneys to be included in the fund. Funds for the equity fund would not depend on increased appropriations. IHS told the court that, if no additional moneys were made available, it would shift existing resources to the equity fund, as necessary. The fund would be allocated exclusively to tribes with the highest levels of relative need.

In accordance with its plan, IHS computed needs by applying a set of standards and criteria 2/ to estimate staffing and/or contract care dollars required for providing a range of health services to Indians within defined service areas. IHS translated the results of these estimates into tribal requirements based on each tribe's population within defined service areas.

IHS also determined the health care resources available to each tribe, including the previous year's authorized IHS resources and other Federal, State, local, and private resources. It then subtracted the available resources from the calculated requirements to determine each tribe's unmet need.

Finally, IHS set priorities for allocating the fiscal year 1981 equity funds by dividing each tribe's unmet need by its requirements to arrive at a percentage deficiency and then stratified these percentages into five groups. Level I tribes had the least deficiency (less than 20 percent), and Level V tribes had the greatest (between 81 and 100 percent). By the end of fiscal year 1984, IHS hoped that no tribe's deficiency would be greater than 60 percent.

1/618 F. 2d 569 (1980).

2/Currently known as the Resource Requirements Methodology; formerly known as the Resource Allocation Criteria.

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OBJECTIVES, SCOPE, AND METHODOLOGY

To assess IHS' plan for distributing the fiscal year 1981 equity health care fund and to review its system for allocating resources, we attempted to answer two major questions:

--Did the equity fund go to the neediest tribes?

--Did IHS develop a system for allocating resources among tribes which results in an equitable distribution of its funds?

We evaluated IHS' system for distributing the fiscal year 1981 equity health care fund by reviewing the (1) methodology used to estimate tribal health care requirements and resources, (2) method to determine the neediest tribes, and (3) equity fund's effect on IHS' distribution of its health services appropriations.

Officials in IHS' Health Services Planning Branch gave us information on how the equity fund operates. We obtained information pertinent to the equity fund's operation from other IHS officials involved in contract health services, financial management, legislation and regulations, program statistics, and program operations.

We also contacted HHS and Health Services Administration officials to obtain information on their guidance to IHS and the legal requirements for the equity health care fund.

We used the IHS staffing standards, the applications of resource requirement standards for IHS service areas, and the analysis of unmet needs to confirm the process and results of the tribes' rankings and equity fund allocations. We did not attempt to validate the resource requirement standards themselves because of the time and cost involved and because IHS had planned to do this. However, in June 1981, IHS reprogramed the funds targeted for this validation study, and the study has not yet begun.

We obtained information on other Federal health care assistance to Indians from the Veterans Administration, the Department of Agriculture, the Health Care Financing Administration, and the Bureau of the Census to gauge the extent to which that assistance reduced tribes' unmet health care needs.

We reviewed the California Program Office's process for distributing the equity health care fund among California tribes because they were allocated $5,825,000, 74 percent of the fiscal year 1981 fund. We did not visit other area or program offices because they were allocated much smaller amounts of equity funds.

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We visited the two major recipients of equity funds--the Riverside/San Bernardino County Indian Health Clinic and the Indian Health Council of California, which were allocated $1,391,000 and $780,000, respectively, in equity funds. We obtained information on their tribal requirements, services currently available, and plans for spending equity funds.

We discussed the effects of the equity health care fund with other tribal groups in California, including several clinic administrators. California State Department of Health officials were interviewed to obtain information on State health funds for Indians and allocation formulas.

Our review, which was conducted in accordance with the Comptroller General's "Standards for Audit of Governmental Organizations, Programs, Activities, and Functions," took place between April and December 1981.

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CHAPTER 2

IHS MAY NOT HAVE DISTRIBUTED EQUITY FUNDS TO THE NEEDIEST TRIBES

IHS, following the plan it presented to the court, allocated its fiscal year 1981 equity fund to 51 tribes which it determined had the greatest relative level of unmet health care needs. (See app. I.) IHS may not, however, have allocated its 1981 equity fund to the neediest tribes because of weaknesses in its needs-based ranking system, including

- --use of inconsistent and unreliable data to develop tribal health requirements,
- --understatement of alternate resources available to supplement IHS health services and reduce unmet need, and
- --exclusion from the system of two multimillion-dollar programs, which distorted tribal rankings.

IHS has taken some actions to correct these weaknesses. However, it needs to expand these efforts to assure that the ranking of tribes and the annual equity fund allocations are appropriate. Only then can IHS be sure that significant progress will be made toward achieving the overall goal for the equity fund.

EQUITY FUND ACCOMPLISHMENTS

Between April and September 1981, IHS distributed the $7,856,000 fiscal year 1981 equity fund to 51 tribes which it had calculated to be in Level V on its ranking scale for unmet health care needs. IHS' records show that, after allocation of the fund and a new analysis of unmet needs, only two tribes remained in Level V, as shown in the following table.

IHS' Ranking of Tribal Groups

Percent deficiency	Level	Number of tribes As of February 1980	Number of tribes As of November 1981
Less than 20	I	1	10
21 - 40	II	15	30
41 - 60	III	88	95
61 - 80	IV	93	107
81 - 100	V	51	2
Total		a/248	a/244

a/Totals may vary from year to year because of newly recognized tribes and changing tribal health consortiums.

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According to IHS, one tribe remained in Level V because it had been newly recognized as eligible for IHS funding and its 1981 equity funding was calculated without IHS' analysis of the tribe's relative unmet needs. The allocation proved inadequate to raise the tribe to Level IV. IHS could not explain why the second tribe remained in Level V. Two additional tribes have since been recognized as eligible for IHS services and are categorized in Level V.

IHS' REDEFINITION OF REQUIREMENTS AIDED PROGRESS TOWARD COMPARABILITY

When it responded to the Rincon court decision, IHS anticipated needing about $80 million of equity fund moneys to raise all the tribes then in Levels V and IV to Level III. IHS gave us information which showed that, based on the fiscal year 1982 analysis of unmet needs, it would take only about $19 million of equity funds through fiscal year 1984 to bring all tribes to a maximum deficiency level of 60 percent (Level III). About $53 million of the $80 million originally planned for distribution through the equity fund was deleted from IHS estimates when IHS changed its method for calculating tribal requirements in fiscal year 1982.

Eliminating major maintenance and repair needs from the equity analysis accounted for $23 million of the $53 million change from fiscal year 1981 to 1982. Although IHS officials could not quantify the reasons for the $30 million additional reduction, some explanations they offered were:

--IHS used a smaller population for the fiscal year 1982 analysis than it did for the fiscal year 1981 analysis. Formerly, the Indian population was projected to 1984 so IHS could give the Congress a 4-year plan for needed health funds. In its 1982 analysis, IHS used 1982 population data to coincide with the current budget year.

--IHS changed the criteria for community health nursing, reducing staffing requirements in that program by one-third.

--Some tribes changed their methods of service delivery for certain programs from direct care to contract or vice versa.

In fiscal year 1982, IHS plans to distribute through the equity fund $7,636,000 of the estimated $19 million still needed to raise the neediest tribes to the 60-percent deficiency level.

WEAKNESSES IN IHS' RANKING SYSTEM AFFECTED THE FISCAL YEAR 1981 DISTRIBUTION

IHS used inconsistent and/or incomplete information to estimate tribal health care requirements and available resources.

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In addition, IHS excluded two programs from the annual tribal comparison of staffing and contract care needs. As a result, IHS may not have distributed its fiscal year 1981 equity funds to the neediest tribes.

Inconsistent and unreliable data used to develop tribal health requirements

Two major problems affected IHS' measurement of tribal health care requirements. First, the contract health care estimates IHS used were not reliable or consistently developed for each tribe. Second, IHS did not use uniformly developed workload data for all area and program offices. In addition, other technical problems caused inconsistencies in the tribal comparison.

Contract care estimates

Although estimates for contract health care totaled $335 million in the fiscal year 1981 needs-based analysis (35 percent of total requirements), IHS did not have consistent or reliable data for average inpatient and outpatient contract care costs. These estimates significantly affected IHS' calculation of tribal requirements. Fiscal year 1981 contract health care estimates for inpatient costs varied as much as $213 per day among area and program offices within the same geographic region. Also, within each area or program office, year-to-year variations in the contract care estimates were significant. In one office, the average estimated inpatient cost increased from fiscal year 1981 to 1982 by $213 per day (77 percent). Another office's estimate decreased by $105 per day (33 percent). Overall, 5 of the 12 area and program offices showed variations from 1981 to 1982 of more than 20 percent.

In fiscal year 1981, the California Program Office used $346 per inpatient day and $75 per outpatient visit to estimate tribal requirements. In fiscal year 1982, these estimates dropped to $272 and $51, respectively. If the lower estimates had been used in 1981, the program office's requirements would have dropped by about $9 million. This change alone would have meant that $3.7 million (23 percent) less was needed to bring the California tribes to the 60-percent deficiency level.

Concerning these wide variations, IHS officials said that they could not say which estimate was correct or specifically why the variations occurred. A number of factors contributed to the variations:

--IHS used unverified data to develop most of its contract health care estimates.

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--The data base used to develop contract care cost estimates was affected by changes in IHS' accounting and financial management systems.

--IHS' California Program Office did not report contract care data similar to those reported by other IHS area or program offices.

--IHS averaged both partial and full contract care payments, thereby distorting the average costs of services.

--The annual inflation factors used to escalate 1979 average contract care costs to fiscal year 1982 varied from 6 to 45 percent among area and program offices.

IHS officials agreed that the contract care estimates used to analyze unmet needs were based on unreliable data. A computerized edit check was recently implemented to eliminate major, obvious errors from the raw data. As a result, the contract care estimates for fiscal year 1983 analysis of unmet needs should be more reliable. IHS officials also stated that a new cost-accounting system, now being implemented in one program office, will improve future contract care estimates.

Workload estimates

IHS did not obtain uniform workload data to compare the health care requirements of the California tribes with those of other tribes. It developed patient workload estimates for the California clinics based on population and national utilization figures, while data for other areas were developed using actual utilization statistics. This substitution appears to have caused large overstatements of requirements in California.

A California Program Office health planner illustrated the impact of using projected rather than actual workload data based on population. During fiscal year 1979, the Riverside/San Bernardino tribal clinic had about 4,200 outpatient visits and an IHS-eligible target population of 8,548. For planning purposes, IHS assumed that each eligible Indian in California visited a clinic for ambulatory care an average of 5.2 times. Consequently, IHS projected a workload for the Riverside/San Bernardino clinic of 44,450 visits (8,548 x 5.2), over 10 times the actual utilization. Using IHS' average cost per outpatient visit, the outpatient requirements were estimated to be over $3 million higher than the requirements would have been, based on actual experience. In other area and program offices, actual workload data were used to estimate health care requirements and adjusted upward to reflect the belief that the absence of resources may have affected the demand for IHS services.

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Other problems in estimating requirements

IHS experienced several technical problems when applying its needs-based ranking system. These problems caused errors in (1) which tribes qualified for fiscal year 1981 equity funds and/or (2) what amounts tribes received:

--Unlike other area and program offices, the Bemidji Program Office used contract care estimates instead of staffing standards to calculate its alcoholism and emergency medical services needs. As a result, its needs in these programs were about $1.9 million less than if the staffing standards had been used. If staffing standards had been used consistently, one additional tribe would have qualified for equity health care funding.

--Two tribes in the Aberdeen Area Office and three in the Portland Area Office received incorrect allocations of equity funds because IHS did not convert services these tribes shared with others into individual tribal requirements. Of these, four tribes received too little, and one tribe should not have received any equity funds.

--Two tribes received equity funds because their unmet needs were overstated when IHS improperly added one-time requirements for major maintenance and repair. After we brought this matter to the attention of IHS officials, IHS withdrew $695,000 in equity funds from one tribe and $223,000 from another.

IHS has corrected some of these problems for its fiscal year 1982 equity fund distribution by (1) automating its methodology for computing requirements and (2) eliminating major maintenance and repair as a factor in the needs-based ranking system. Some manual adjustments are still needed to correct problems with allocating service area requirements to tribes. However, in the fiscal year 1982 automated needs-based analysis, several large workload errors went unnoticed, resulting in an inaccurate assessment of tribal requirements. IHS said it has also corrected these errors, but a more systematic verification of input data and additional checks on the reasonableness of the output data are needed.

Understatement of alternate resources available to tribes

IHS did not completely or consistently consider all other available resources that reduce tribes' unmet needs. IHS failed to use much of its own data which could have helped in estimating other available resources. Using IHS data and data from other Federal sources, we identified about $49 million in additional health resources serving Indians. Although not all of these

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resources directly offset requirements, improved estimating of these resources is needed to compare tribes fairly.

Using data from IHS' Contract Health Care Branch, we estimated that, for at least 73 tribes, IHS failed to consider fully the resources available to Indians from one or more of the following Federal sources:

--Bureau of Community Health Services projects, such as grants for community health centers, rural health initiatives, maternal and child health, family planning, and National Health Service Corps staff.

--Alcohol, Drug Abuse, and Mental Health Administration projects.

--Office of Human Development Services grants to Indians from the Administration for Children, Youth and Families and the Administration on Aging.

--The Department of Agriculture's Special Supplemental Food Program for Women, Infants, and Children.

--The Community Services Administration's Community Food and Nutrition grants.

IHS also failed to consistently consider Medicare or Medicaid reimbursements for services provided to Indians in IHS facilities under title IV of the Indian Health Care Improvement Act (Public Law 94-437). As shown in the following table, IHS has spent and plans to spend significant amounts of Medicare and Medicaid reimbursements to meet staffing and contract care needs in its facilities.

Fiscal year	(millions)
1980	$ 4.4
1981	9.8
1982 (planned)	21.0

Even though these funds have directly reduced tribes' unmet health staffing needs, IHS had not consistently included them in its analysis.

Furthermore, IHS had not estimated other third-party reimbursements which reduce unmet needs. Individually held health care coverage--such as Medicare or Medicaid, veterans' benefits, and private health insurance--are significant for Indians. We noted that:

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--About 63 percent of all Indians have private health insurance, according to unpublished data from the National Center for Health Statistics. For Indians in standard metropolitan statistical areas, the estimate is about 60 percent; for those in other areas, it is about 68 percent.

--Medicaid payments for Indians in States with Indians eligible for IHS services totaled $47 million in fiscal year 1980 (excluding several States, such as California, Alaska, and New York, which did not report Medicaid payments by race).

--During fiscal year 1980, 3,847 Indians were discharged from Veterans Administration hospitals. Matching these discharges to areas with Indians eligible for IHS services, we estimated these benefits at about $5.8 million based on IHS contract costs and average length of stay.

While not all of the above offset tribes' requirements for health care services included in the analysis of unmet needs, some do. When it distributed the 1981 equity fund, IHS made no attempt to use its contract care records to estimate Medicare and Medicaid payments, veterans' benefits, or privately held insurance that offset services provided Indians outside the IHS setting. IHS contract care records are required to include information such as itemized billings which can be used to estimate other health care coverage available to IHS beneficiaries.

In July and August 1981, IHS revised its directives to improve the reporting of alternate resources available to tribes, for use in its needs-based analysis in fiscal year 1983. Specifically, IHS issued an inventory of funding sources available to tribes and additional instructions to obtain more consistent reporting of these resources. However, these directives do not specify how privately held coverage--such as Medicaid, Medicare, veterans' benefits, and private insurance coverage--should be quantified and reported.

Tribal comparison excludes two programs

In determining which tribes should receive equity funds, IHS excluded its community health representatives and emergency medical services programs from its analysis even though IHS allocated $45 million, over 7 percent of its fiscal year 1981 health services appropriation, for these programs. Omitting these programs from the needs-based analysis resulted in inequitable tribal comparisons.

Because some tribes received full funding of their needs in the community health representatives and/or emergency medical services programs and others had none of their needs met, the tribal rankings would have changed if these programs had been

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included in the equity fund analysis. Recognition of this factor would have resulted in eight fewer tribes falling in Level V before the distribution of the 1981 equity fund.

IHS administratively decided which programs would be considered in the equity analysis. IHS did not, however, restrict tribes' equity fund expenditures to the qualifying programs. Several California tribes planned to spend equity funds for community health representatives or emergency medical services although they did not qualify for equity funds because of deficiencies in these programs.

IHS officials told us that, in the future, they will restrict expenditure of equity funds to those program deficiencies which caused tribes to qualify for equity funds. However, they continued to exclude the community health representatives and emergency medical services programs in the fiscal year 1982 equity fund analysis even though IHS' analysis showed that the funds in the programs had not been equitably distributed.

CONCLUSIONS

IHS succeeded in distributing its fiscal year 1981 equity fund so that all but two tribes were raised on the IHS scale of health care deficiency from Level V to at least Level IV. It also may succeed in raising all tribes to Level III or above on its scale by the end of fiscal year 1984. Most of this progress is attributable to IHS' recalculation of tribal requirements for health care services rather than to the distribution of the equity fund.

However, several shortcomings affected the consistency and comparability of its estimates of tribal requirements and the resources available to satisfy these requirements. As a result, IHS may not be distributing the equity fund to the neediest tribes.

IHS has made several improvements in its needs-based ranking system, some of which will affect the fiscal year 1982 equity fund distribution but most of which will have no effect until the 1983 distribution.

IHS needs to further improve its needs-based ranking system to assure that its distributions of the fiscal years 1983 and 1984 funds achieve the overall goal for the equity fund.

RECOMMENDATIONS TO THE SECRETARY OF HEALTH AND HUMAN SERVICES

To improve the needs-based ranking system, we recommend that the Secretary require the Director of IHS to:

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--Develop more reliable data for estimating health care requirements and available resources, including (1) accurate and complete contract health care estimates and (2) uniformly developed and verifiable workload data.

--Develop a mechanism for identifying and reporting alternate resources which offset health care requirements.

--Include community health representatives and emergency medical services programs in the comparison of tribes' health care services.

AGENCY COMMENTS AND OUR EVALUATION

In commenting on a draft of this report (see app. II), HHS concurred with our recommendation calling for the development of more reliable data for estimating tribal health care requirements and available resources. HHS stated that actions taken or planned include:

--The California Program Office will be instructed to report average inpatient and outpatient contract care costs according to IHS established procedures.

--A computerized edit check was implemented to purge gross errors from the raw data.

--A recently installed Contract Health Service Management Information System for IHS area and program offices, when fully implemented, will systematically capture base workload and cost data so that their quality and reliability will be improved.

Also, HHS said that a task force has been established to develop a methodology to improve the reporting of alternate health care resources. HHS stated, however, that it was misleading to cite national sources of alternate health care resources as evidence of IHS' failure to consider completely or consistently all alternate resources available to tribes. HHS agreed that some of these resources are significant, but noted that no complete inventory of all alternate resources is available.

We agree that no complete inventory exists. However, as discussed on pages 9 and 10, many of the resources we reviewed were omitted from IHS analyses. We used national sources of data to estimate private health insurance, veterans' benefits, and Medicare and Medicaid because IHS did not have information for its eligible population. We are not suggesting that IHS use these data, but rather that IHS develop a mechanism to estimate these alternate resources.

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HHS disagreed with our recommendation to include the community health representatives and the emergency medical service programs in the annual comparison of tribes' health care services. According to HHS, these programs have been excluded because they are not part of the Public Law 94-437 (Indian Health Care Improvement Act of 1976) benefit package. HHS stated that the two excluded programs have a separate system for distributing their program funds. HHS noted that only those programs of highest priority are included for distribution of equity funds.

HHS' comments suggest that the community health representatives and the emergency medical service programs were excluded from the annual process of comparing tribes' health care services because of requirements established by Public Law 94-437. This is not the case. As stated on page 12, the programs to be included in the analysis were administratively determined by IHS and, accordingly, can be changed administratively.

We recommended that the community health representatives and the emergency medical service programs be included in the annual comparison of tribal health care services because of the impact their omission had on the number of tribes qualifying for equity funds. As noted on page 12, if these programs had been included, eight fewer tribes would have qualified for equity funds in fiscal year 1981 and moneys would have been distributed more equitably. Therefore, we believe that our recommendation is still valid and that HHS should include these two programs in the annual comparison of tribes' health care services.

In addition, HHS comments seem to suggest that we are recommending that the community health representatives and the emergency medical service programs also be funded through the equity fund. This is not the case. We are only recommending these programs be included in the annual comparison of tribes' health care services, which forms the basis for distributing equity funds. IHS can continue using the existing mechanism for distributing the funds for these two programs.

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CHAPTER 3

IHS NEEDS A MORE EQUITABLE APPROACH FOR DISTRIBUTING ITS HEALTH SERVICES FUNDS

The equity fund, by itself, will not correct the major problems caused by IHS' funding distribution system. When, as planned, the equity fund is discontinued at the end of fiscal year 1984, IHS should have in place a system that equitably distributes its health services funds. To do this, IHS should eventually make two fundamental changes:

--Abandon its longstanding practice of funding programs and tribes based on the previous year's funding level (program continuity).

--Use standards and criteria for distributing all of its health services appropriated funds.

In the interim, IHS can correct funding disparities such as those identified in the Rincon case. The needs-based ranking system that IHS used for distributing the equity fund could have served as the basis for distributing about 60 percent of IHS' fiscal year 1981 health service appropriations. IHS has limited its use of this system to the equity fund--1.3 percent of IHS' fiscal year 1981 health services appropriations.

IHS could also incrementally increase the amount of money in the equity fund so that, by the end of fiscal year 1984, it will have begun to distribute significant amounts of money using rational standards and criteria.

IHS ADHERENCE TO "PROGRAM CONTINUITY" LEADS TO INEQUITIES

IHS is attempting to achieve equity while maintaining program continuity. The equity fund is distributed based on need, but the bulk of IHS health services appropriations are allocated based on the level of the prior year's funding. While maintaining funding of programs may be desirable to IHS, we believe this practice will not lead to an equitable distribution of funds.

Rincon court criticized IHS' allocations based on program continuity

During fiscal years 1965-78, allocations based on program continuity and mandatory cost increases for ongoing programs accounted for between 87 and 99 percent of IHS health services appropriations. In the Rincon case, the Court of Appeals for the Ninth Circuit criticized this IHS practice and concluded that

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> "* * * A system that allocates funds to programs merely because the programs received funds the previous year, regardless of whether the programs are ineffective, unnecessary or obsolete is not rationally aimed at an equitable division of funds * * *."

Both the appeals court and the district court that originally ruled on the Rincon case cited another case, Morton v. Ruiz, 1/ as precedent for criticizing IHS. The appeals court gave the following interpretation of IHS' responsibilities:

> "* * * The IHS has expressly stated that it is unable to reach all eligible beneficiaries of its health services with the funds currently appropriated for it by Congress. Ruiz therefore, requires that the IHS establish and consistently apply a reasonable standard for the allocation of its limited health services and facilities budget. While Ruiz does not explicitly state that the standard must be rational or result in an equitable distribution, it stresses that the purpose of establishing a clear standard is to prevent arbitrary denial of benefits. We can infer from this that the Court in Ruiz intended that the administering agency [IHS] develop criteria for distribution that are rationally aimed at an equitable division of its funds * * *."

Standards and criteria form the basis for IHS' needs-based ranking system. However, IHS has used this system for distributing less than 2 percent of its fiscal year 1981 health services appropriations.

Program continuity funding continues inequities

Despite the Rincon case, IHS has not fundamentally altered the way it distributes the bulk of its health care funds to tribes. It still distributes almost all of its funds based on program continuity. About 96 percent of IHS' $594 million fiscal year 1981 health services appropriation was allocated based on tribes' and programs' prior year's funding. The major exceptions to this practice were the equity fund, some congressionally earmarked funds, and certain mandatory cost increases. However, excluding one-time funds, these exceptions increase the tribes' and programs' funding bases used in subsequent years under IHS' program continuity policy. For example, moneys distributed through the fiscal year 1981 equity fund become part of a tribe's ongoing funding base in fiscal year 1982 and thereafter.

1/415 U.S. 199 (1974).

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IHS officials gave the following reasons for their continued reliance on program continuity.

--Ongoing programs for which there is an established need would be disrupted if funds were shifted from one tribe or group to another. After tribes' program needs for health services have been funded, those needs continue to exist and IHS is not inclined to reduce some tribes' funding so that it can increase funding for others.

--Tribal groups in California and other relatively underfunded areas may be unable to absorb large funding increases.

IHS officials believed that phased incremental funding through the equity fund will minimize hardships resulting from shifting of funds and provide for orderly and measured growth of the tribes with the greatest levels of unmet need. (See p. 2.)

IHS' phased approach can eliminate funding disparities among tribes in the near future only if substantially increased health services appropriations are available. This is unlikely in view of current efforts to control Federal expenditures. IHS needs, therefore, to recognize that it will be difficult, if not impractical, to eliminate funding disparities while maintaining each tribe's level of funding.

Based on IHS' ranking of tribes for fiscal year 1982, it is likely that 40 tribes will be in Levels I and II and 206 tribes in Level III if IHS' equity fund goals are achieved by the end of fiscal year 1984. Because of program continuity, Level I and II tribes will continue to have relatively fewer unmet needs than Level III tribes. According to IHS' ranking scale, the funding differential between tribes could be as much as 60 percent of unmet needs.

INCREASED USE OF THE NEEDS-BASED RANKING SYSTEM COULD LEAD TO MORE EQUITABLE FUNDING

To eliminate funding disparities, IHS will need a more equitable system for distributing funds. Before discontinuing the equity fund, IHS needs to reduce--at least incrementally--its dependence on program continuity as a basic funding policy element and rely instead on standards and criteria for funding decisions. In its needs-based ranking system, IHS has a mechanism which could be used to that end in two ways.

First, IHS could use its needs-based ranking system to distribute a much larger portion of its health services appropriations. In fiscal year 1981, IHS could have applied its ranking system to

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distribute about $342 million (about 60 percent of its health services appropriation). These moneys were distributed for staffing Indian health facilities and providing contract health care to Indians.

IHS, however, restricted the use of the ranking system to distributing the $7,856,000 earmarked by the Congress for the 1981 equity fund. In fiscal year 1982, IHS plans to distribute, at most, $7,636,000, or 1.3 percent of its health services appropriation, using the needs-based ranking system--about the same as in fiscal year 1981.

As a second approach, IHS--without asking for increased appropriations--could request from the Congress incrementally greater amounts of funds for distribution through the equity fund. This would gradually reduce IHS' reliance on program continuity as the principal funding element and correspondingly increase emphasis on needs-based funding.

If it were to use either of these approaches, IHS could also determine the extent to which it will consider other important funding factors, including the tribes' ability to effectively spend the IHS funds they receive.

CONCLUSIONS

IHS' current funding distribution system, including the corrective elements of the equity fund, will not result in an equitable distribution of IHS health care funds in the foreseeable future. IHS can develop a more equitable system for distributing its health services appropriations that will not only raise tribes' funding to the 60-percent deficiency level, but also significantly reduce funding disparities among tribes. To do this will require IHS to revise its longstanding policy of funding tribes based on prior years' funding (program continuity) so that it can distribute funds on a more equitable basis.

The needs-based ranking system which IHS used for its equity fund could provide the vehicle for developing an equitable funding process, which should be in place when the equity fund is discontinued.

IHS could either (1) immediately begin to apply its needs-based ranking system to distribute that portion of its health services appropriations for which it has already established standards and criteria or (2) incrementally increase the amount of funds distributed through the equity fund mechanism. If IHS chooses either of these alternatives, it should be well along toward fully implementing an equitable funding distribution process when the equity fund is discontinued.

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If, on the other hand, IHS elects to retain its policy of funding tribes on a program continuity basis, it may have to retain the equity fund indefinitely as a corrective measure because of continuing disparities of health services funding among tribes.

RECOMMENDATION TO THE SECRETARY OF HEALTH AND HUMAN SERVICES

We recommend that the Secretary require the Director of IHS to develop and implement a more equitable funding allocation system by the end of fiscal year 1984, when the equity fund is expected to be discontinued. Specifically, the Director should be required to reduce and eventually abandon reliance on program continuity and, in its place, use standards and criteria that will distribute IHS funds equitably.

AGENCY COMMENTS AND OUR EVALUATION

In commenting on a draft of this report (see app. II), HHS disagreed with our recommendation that IHS gradually reduce and eventually abandon its reliance on program continuity and, in its place, implement a more equitable funding allocation system based on standards and criteria by the end of fiscal year 1984. HHS stated that IHS does not fund the same program year after year, but that in some cases, the continuity of a program's funding level without essential change is programmatically desirable. According to HHS, IHS uses a mechamism based on actual health care delivery system use when making decisions on the amount of funds to be provided a tribe or the funding level of a program. HHS stated that redirecting significant levels of funds from established health delivery systems would be inconsistent with IHS goals and congressional intent. In addition, HHS stated that some of the funding disparities noted in our report will probably continue to exist indefinitely because no funding mechanism can be exact enough to account for all variables in allocating resources. HHS stated that IHS will continue to refine its systematic allocation procedures to be more precise and sensitive to changing health delivery patterns, tribal needs, and IHS management needs.

If IHS believes that a significant redirection of funds would be necessary to achieve equity and that this would adversely affect ongoing programs, then a phased approach may be preferable. IHS should choose our alternative, which calls for gradually decreasing the dependence on program continuity. It does not appear to us that such redirection of funds would be inconsistent with congressional intent, since in June 1981 the House Committee on Appropriations reported its concern over IHS' reluctance to examine ways to more equitably distribute the entire health services budget. Accordingly, the Committee requested IHS to prepare detailed methodologies for redistributing the base health services program funds, including the potential impact of such redistribution.

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While we agree that IHS uses not only program continuity but also a needs-based system to distribute its funds, program continuity is more influential in determining funding levels. Although IHS policy may not be to fund a program year after year, as a practical matter, this is what happens, except for certain one-time funds. As noted on page 15, less than 2 percent of IHS' fiscal year 1981 health services appropriations were distributed in accordance with IHS' needs-based system. Most IHS funds, including the equity fund, become part of a tribe's or program's funding base in later years under IHS' program continuity policy.

Regarding IHS' efforts to refine its needs-based system, we believe that the benefits derived from such efforts will be limited until increased amounts of IHS health service moneys are allocated on the basis of need rather than prior funding. In our opinion, IHS should take advantage of the opportunity it now has to improve its funding allocation system before the equity fund is discontinued. If IHS does not follow this course of action, we believe that equity fund mechanism may be needed indefinitely, and that the present funding inequities among tribes and IHS programs may continue.

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APPENDIX I

DISTRIBUTION OF THE FISCAL YEAR

1981 EQUITY HEALTH CARE FUND

	Allocation (thousands)
Aberdeen Area Office:	
Iowa:	
Sac and Fox of Mississippi	$ 127
Nebraska:	
Santee Sioux	34
North Dakota:	
Trenton-Williston	27
South Dakota:	
Flandreau Santee Sioux	196
Subtotal - Aberdeen	384
Alaska Area Office:	
Copper River	269
Kodiak	126
North Pacific Rim	103
Subtotal - Alaska	498
Bemidji Program Office:	
Michigan:	
Grand Traverse of Ottawa	81
Minnesota:	
Fond du Lac	203
Wisconsin:	
Wisconsin Winnebago	169
Subtotal - Bemidji	453

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	Allocation (thousands)
California Program Office:	
Berry Creek	$ 13
Cahuilla	20
Campo	75
Central Valley	253
Cortina	31
Coyote Valley	69
Enterprise	13
Grindstone	113
Indian Health Council	780
Mendocino County	112
Montgomery Creek	6
Northern Sierra	144
Northern Valley	421
Pechanga Band	62
Riverside - San Bernardino	1,391
Roaring Creek	8
Robinson Rancheria	14
Santa Ynez	16
Shasta - Trinity - Siskiyou	710
Shingle Springs	47
Sonoma County	472
Sulphur Bank	27
Tule River	245
Tuolumne	183
United Indian Health Services Project	600
Subtotal - California	5,825
Phoenix Area Office:	
Nevada:	
Lovelock Paiute	5
Utah:	
Southern Paiute	100
Subtotal - Phoenix	105

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	Allocation (thousands)
Portland Area Office:	
Oregon:	
Burns Paiute	$ 25
Washington:	
Hoh	8
Lower Elwha	55
Muckleshoot	67
Nisqually	28
Nooksack	40
Quileute	56
S. Klallam	60
Sauk Suiattle	25
Skokomish	36
Squaxin Island	57
Suquamish	63
Tulalip	52
Upper Skagit	19
Subtotal - Portland	591
Total	$7,856

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

MAY 20 1992

Mr. Gregory J. Ahart
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft of a proposed report "The Indian Health Service Not Yet Distributing Funds Equitably Among Tribes." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Richard P. Kusserow
Inspector General

Enclosure

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COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ON THE GENERAL ACCOUNTING OFFICE'S DRAFT REPORT, "THE INDIAN HEALTH SERVICE NOT YET DISTRIBUTING FUNDS EQUITABLY AMONG TRIBES," DATED APRIL 13, 1982

GAO Recommendation

To improve the needs-based ranking system, we recommend that the Secretary require the Director of IHS to:

--Develop more reliable data for estimating health care requirements and available resources, including accurate and complete contract health care estimates, uniformly developed and verifiable workload data, and sources for reporting alternative resources which offset requirements.

--Include community health representatives and emergency medical services programs in the comparison of tribes' health care services.

Department Comment

We concur with the first part of the recommendation. The adverse variations in base data collections brought to our attention in the General Accounting Office (GAO) report have been corrected or are in the process of being resolved. For example:

--The California Program Office will be instructed to report average inpatient and outpatient contract care costs according to the IHS procedures established for all area and program offices.

--A computerized edit check was implemented to purge gross reporting errors from the raw data.

--The recently installed Contract Health Service Management Information System for area and program offices, when fully implemented, will systematically capture base workloads and costs so that their quality and reliability will be improved.

We will continue to work with tribes to improve the accuracy of data collected.

The IHS needs-based ranking system includes a Resource Requirement Methodology (RRM) for measuring tribal health service requirements. The RRM procedures embody actual utilization experience, prevailing national standards and criteria, actual workload data, and official tribal population statistics to determine staffing and other resource requirements. The RRM also provides justifications for personnel increases in new or replacement facilities.

To develop demand forecasts, outpatient visits per capita are determined. Actual inpatient and ambulatory patient workload data are used. The demand forecast is computed from the previous year's workload factors and the latest tribal population figures. The actual workloads are verifiable. The guidelines for reporting of alternate resources

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which must be specific to tribes and programs were developed and provided not only to the IHS area and program offices but also to the tribal organizations. The further improvement and uniform reporting of alternate resources has been assigned to a task force for inclusion in the next annual application process.

As it has in the past, and as necessary, IHS will continue to improve its forecasting methodology for estimating health care fund distributions to the most needy tribes.

We do not concur with the second part of the recommendation which states that the Community Health Representative (CHR) and the Emergency Medical Service (EMS) programs be included in the annual comparison of tribes' health care services. It is important to note that only those programs of highest priority have been included for distribution of equity health care funds. The IHS policy on CHR and EMS programs is as follows:

> The CHR and EMS programs are included in the Services' Resource Requirement Methodology for measuring health service requirements. However, these two programs are not included for participation in the distribution of equity health care funds because they are not considered part of the P.L. 94-437 benefit package (Indian Health Care Improvement Act of 1976). The two excluded programs, furthermore, have a separate system for the distribution of their particular program funds.

GAO Recommendation

We recommend that the Secretary require the Director of IHS to develop and implement a more equitable funding allocation system by the end of fiscal year 1984, when the equity fund is expected to be discontinued. Specifically, the Director should be required to reduce and eventually abandon reliance on program continuity and, in its place, use standards and criteria that will distribute IHS funds equitably.

Department Comment

We do not concur. The report did not give adequate credit to the statistical and analytical systems which IHS uses in drawing up and comparing levels or equitable shares of IHS services and funds among the service populations. IHS will continue to refine its systematic allocation procedures to be more precise and sensitive to changing health delivery patterns, tribal needs, and IHS management needs.

IHS has also developed and implemented a health services priority system which identifies the tribal eligibility for priority funding. The priority system was used to allocate the equity health care funds in Fiscal Year 1981. The systems referred to here are described in IHS' Resource Allocation Plan which was prepared for submission to the Congress and can be made available to GAO upon request.

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The development of the IHS health delivery system has been phased in incrementally in accordance with congressional intent expressed in P.L. 94-437, Indian Health Improvement Act of 1976. IHS does not fund the same program year-after-year. In some cases, the continuity of a particular program award without essential change is a programmatic desideratum for an uninterrupted duration of time. To redirect significant levels of funds from established health delivery systems would not be consistent with IHS goals and the congressional intent. Program disruptions and decreased levels of health services would result if hospital wards or health centers were closed by mere diversion of funds.

GAO contends that IHS only considers program continuity when making decisions on the amount of funds to be provided a tribe or the funding level of a program. This is not correct. IHS uses a system which is based on actual use of its services to determine funding levels. Alternative sources of care are included where they are known, but only individuals who have used IHS sponsored services are in the system's universe. Therefore, the IHS needs based system is self adjusting.

Some of the funding disparities mentioned in the report will probably continue to exist indefinitely because no funding mechanism can be exact enough to account for all variables in the allocation of resources. The variables include a) the collective health status of each tribe; b) the prevalence of disease; c) the physical geographical location; d) per capita income; e) educational level; f) accessibility to various health care facilities; and g) tribal attitudes and resourcefulness. All of the tribes will continue to have some degree of health care deficiencies which are not susceptible to correction by funding allocations.

Technical Comments

In Chapter 2, GAO states that IHS did not consider completely or consistently all alternate resources available to tribes. The citing of national sources of alternate resources in this connection is misleading. Alternate resources such as Medicare or Medicaid reimbursements are significant for IHS funded health care operations. However, alternate resources must be tribal and program specific. No complete inventory exists of all available alternate resources available to particular tribes.

Guidelines were made available to each tribe for reporting their alternate resources to IHS. Other alternate resources were identified through the Department's regional offices. Nevertheless, it must be recognized that some tribes do not participate in the full scope of available HHS programs. A task force has been established to develop a methodology to further improve the complete and uniform reporting of alternate resources.

In Chapter 2, GAO stated, "We noted that: -- About 63 percent of all Indians have private health insurance, according to unpublished data

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from the National Center for Health Statistics. For Indians in standard metropolitan statistical areas, the estimate is about 60 percent; for those in other areas, it is about 68 percent."

Most of the Indians residing on or near Indian reservations are a poverty-stricken class of Americans. The isolated rural areas in which they live have very high unemployment rates. Consequently, these persons do not enjoy a significant degree of private health insurance coverage.

(102064)